Management of Alcohol Use Disorder

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Substance Use Warmline TA Office Hours:
Management of Alcohol Use Disorder

October 22, 2020

Lara Chausow, PhD
Data Statistician, Quality Division, Office of Quality Improvement
Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People
Health Center Program Patients

HRSA-Funded Health Centers Improve Lives

Nearly 30M people—that’s 1 in 11 in the U.S.—rely on a HRSA-funded health center for care, including:

- 1 in 8 children
- 1 in 5 rural residents
- 1 in 3 living in poverty
- 1 in 5 Medicaid recipients
- 398K+ veterans
- 885K+ served at school-based health centers
- 1M+ agricultural workers
- 1.4M+ homeless

Source: Uniform Data System, 2019

Health Centers: Substance Use Disorder Services

- More than 97% of HCs providing MH services
- 325,732 Patients receiving SUD Services
- Over 1.8 Million SUD Clinic Visits

SUD and Primary Care Integration

- 36% Increase in the number of patients receiving SBIRT from 2017-2019
- 121% Increase in the number of patients receiving MAT services from 2017-2019
- 32% Health Centers currently providing telehealth for SUD treatment in 2019

Health Center Program SUD Services 2017-2019

Patients Receiving SBIRT

- 2017: 550,000
- 2018: 1,381,408
- 2019: 1,500,000

Patients Receiving MAT

- 2017: 64,007
- 2018: 84,528
- 2019: 142,919

Training and Technical Assistance [T/TA] Resources:

- UCSF National Clinician Consultation Center’s Substance Use Warmline: [https://nccc.ucsf.edu/clinical-resources/substance-use-resources/](https://nccc.ucsf.edu/clinical-resources/substance-use-resources/)
Fetal Alcohol Spectrum Disorder (FASD) occurs in up to 5% of school-aged children.

Prevent FASD and care for children affected by it by joining the HRSA funded SAFEST Choice Learning Collaborative which will enroll Community Health Centers (CHC) in New England (MA, VT, ME, RI, NH, CT) & Upper Midwest (MN, ND, SD, WI, IA, MI) to participate in 10 free virtual Prenatal and/or Pediatric ECHO® sessions from 3/2021 – 2/2022.

- Prenatal ECHO aims to reduce prenatal alcohol exposure by teaching healthcare teams how to screen for and counsel women about the risks of alcohol use during pregnancy
- Pediatric ECHO aims to improve FASD outcomes by training healthcare teams how to identify and care for children and adolescents with suspected or diagnosed FASD
- CHCs will receive a stipend, technical assistance and free continuing education credits
- This is a partnership between Boston Medical Center and Minnesota-based Proof Alliance

For more information on how your CHC can be part of the SAFEST Choice Learning Collaborative, email Kendra Gludt at kendra.gludt@proofalliance.org

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Disclosures

I have no financial disclosures.

I will be discussing off-label use of some medications.

Today’s Content

Part I. Unhealthy alcohol use in public health and primary care

Part II. Treatment of alcohol use disorder

Part III. Ambulatory management of alcohol withdrawal

Part IV. Harm reduction approaches to alcohol use
Learning Objectives

(a) Recognize the detection problem and treatment gap facing patients with alcohol use disorder (AUD)

(b) Relate alcohol use as a critical and potentially modifiable risk factor for clinical outcomes

(c) Expand the toolbox of evidence-based pharmacologic and psychosocial treatment strategies for alcohol use disorder

(d) Describe outpatient withdrawal management and considerations that have been raised in response to an evolving care delivery landscape

Part I. Unhealthy alcohol use
Unhealthy alcohol use

- 93,000 deaths (255 per day) and 2.7 million years of potential life lost (29 years lost per death, on average) in the United States each year to excessive alcohol use
- Exceeds deaths from opioid overdoses
- Prevalence and harms are on the rise, especially among certain groups

Esser et al, 2020; Grant BF et al, 2015; White et al, 2020; Katcher, Reiter, & Aragon, 2010

"Reflecting on the consequences of alcohol-related morbidity and mortality through the age range, our findings document an urgent public health crisis calling for concerted public health action."

Spillane et al, 2020
Noteworthy increases in deaths among women, American Indian/Alaskan Native individuals, and younger age groups

People are experiencing increased stress due to the COVID-19 pandemic
Alcohol use causes most harm compared to other substances

Nutt et al., 2010

Widespread physical and psychosocial problems

- Primary care issues
- Hypertension
- Diabetes
- Depression
- Cancer
- Early pregnancy loss
- Trauma
- Falls
- Motor vehicle accidents
- Risky sex
- Interpersonal Violence
- Poor nutrition
- Firearm violence
- Medication interactions
- Suicide
- Adverse childhood events

US Burden of Disease Collaborators, 2013; Sterling et al, 2020
Unhealthy alcohol use goes undetected

- 1 in 6 patients reports being asked about drinking
- USPSTF recommends screenings in primary care settings in adults, and providing persons engaged in at risk or hazardous drinking with brief behavioral counseling interventions (B recommendation)

Example screening questions

- “Do you sometimes drink beer, wine or other alcoholic beverages?”
- “How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?”

ATTOC
Please circle the answer that best suits the patient:

1. How often do you have a drink containing alcohol?
   - Never
   - Rarely
   - Occasionally
   - Every week
   - Every day

2. Have you ever tried to cut down or stop drinking but were not able to?
   - Yes
   - No

3. In the past year, how many times have you had 5 (for men) or 4 (for women) or more drinks in a day?
   - More than 5 times
   - 3-4 times
   - 1-2 times
   - 1 time
   - Never

4. Have you ever felt convinced you needed a drink to ‘cheer up’ or to ‘keep from being depressed’?
   - Yes
   - No

5. Have you ever felt guilty or punished yourself because of drinking?
   - Yes
   - No

6. Have you ever had a physical or emotional problem because of drinking?
   - Yes
   - No

7. Have you ever had a problem with your family or friends because of your drinking?
   - Yes
   - No

8. Have you ever tried to cut down or stop drinking but were not able to?
   - Yes
   - No

9. Have you ever lost a job or had a chance to win money because of your drinking?
   - Yes
   - No

10. Have you ever driven when you knew you were too drunk to drive?
    - Yes
    - No

11. Have you ever passed out from drinking?
    - Yes
    - No

12. Have you ever felt you needed a drink first thing in the morning to ‘straighten out’ after being drunk the night before?
    - Yes
    - No

13. Have you ever gone a whole day without drinking? (If yes, please circle the answer)
    - Yes
    - No

Scoring: Add numbers in the boxes for each question to get your total score.

- A score of 6 or more requires intervention.
- A score of 4 or more indicates a potential alcohol problem.
- A score of 2 or more indicates an alcohol problem that warrants attention. 

SBIRT
AUD treatment gap is massive

• <10% of patients with unhealthy alcohol use receive treatment
• Of those, only about 50% receive pharmacotherapy

Substance Abuse and Mental Health Services Administration, 2010; Cohen E et al, 2007; Williams et al, 2017

Part II. Treatment of Alcohol Use Disorder
At-risk drinking

Alcohol use disorder

Unhealthy alcohol use

DSM-5: 2+ symptoms over 12 months indicate alcohol use disorder

<table>
<thead>
<tr>
<th>In the past year, have you...?</th>
<th>Interpretation</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had times when you ended up drinking more, or longer than you intended?</td>
<td>Control: exceeded own limits</td>
<td>Impaired control</td>
</tr>
<tr>
<td>More than once wanted to cut down or stop drinking, or tried to, but couldn’t?</td>
<td>Unable to cut back</td>
<td>Impaired control</td>
</tr>
<tr>
<td>Spent a lot of time drinking? Or being sick or getting over the aftereffects?</td>
<td>Compulsion</td>
<td>Impaired control</td>
</tr>
<tr>
<td>Experienced craving — a strong need, or urge, to drink?</td>
<td>Craving</td>
<td>Impaired control</td>
</tr>
<tr>
<td>Found that drinking — or being sick from drinking — often interfered with taking care of your home or family? Or caused job troubles? Or school problems?</td>
<td>Role failure</td>
<td>Social impairment</td>
</tr>
<tr>
<td>Continued to drink even though it was causing trouble with your family or friends?</td>
<td>Consequences: relationship trouble</td>
<td>Social impairment</td>
</tr>
<tr>
<td>Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?</td>
<td>Gave up meaningful activities</td>
<td>Social impairment</td>
</tr>
<tr>
<td>More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?</td>
<td>Risk of bodily harm</td>
<td>Risky use</td>
</tr>
<tr>
<td>Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?</td>
<td>Physical/psychological consequences</td>
<td>Risky use</td>
</tr>
<tr>
<td>Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?</td>
<td>Tolerance</td>
<td>Physiological criteria</td>
</tr>
<tr>
<td>Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sexual things that were not there?</td>
<td>Withdrawal</td>
<td>Physiological criteria</td>
</tr>
</tbody>
</table>
Brief counseling intervention is effective for at-risk drinking

10-15 minutes of counseling:
- Ask permission to raise the subject
- Relate drinking behavior to problems
- Elicit motivations for change
- Set a drinking goal
- Support efforts
- Refer to cognitive behavioral therapy or a mutual help group
- Arrange close follow-up

National Institute on Alcohol Abuse and Alcoholism (NIAAA), 2005
### FDA-approved medications for AUD: Naltrexone

<table>
<thead>
<tr>
<th>Dosage</th>
<th>Oral 50 mg/day</th>
<th>Intramuscular 380 mg/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism</td>
<td>Opioid receptor antagonist that reduces rewarding effects of alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number Needed to Treat (NNT) = 20 to prevent return to any drinking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NNT = 12 to prevent return to heavy drinking</td>
<td></td>
</tr>
<tr>
<td>Pros</td>
<td>OK to use if actively drinking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily oral AND long-acting injectable options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cheap and available</td>
<td></td>
</tr>
<tr>
<td>Cons</td>
<td>Gastrointestinal effects, headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liver concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoid if Child-Pugh C or greater, or alanine aminotransferase (AST)/aspartate aminotransferase (ALT) &gt;5x upper limit of normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor liver function tests baseline, 6 mo, annually</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abstinence from opioids prior to initiation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opioids not as effective for emergency analgesia</td>
<td></td>
</tr>
</tbody>
</table>

Jonas, JAMA, 2014; Rosner et al, 2010

### FDA-approved medications for AUD: Acamprosate

<table>
<thead>
<tr>
<th>Dosage</th>
<th>666 mg orally three times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism</td>
<td>Modulates glutamate neurotransmission</td>
</tr>
<tr>
<td></td>
<td>Maintains abstinence, NNT = 9 to prevent return to any drinking in 8-24 weeks</td>
</tr>
<tr>
<td>Pros</td>
<td>Safe for the liver</td>
</tr>
<tr>
<td></td>
<td>Can use in setting of opioid use</td>
</tr>
<tr>
<td>Cons</td>
<td>TID adherence</td>
</tr>
<tr>
<td></td>
<td>Requires renal dosing</td>
</tr>
<tr>
<td></td>
<td>50% reduction for moderate renal impairment</td>
</tr>
<tr>
<td></td>
<td>Contraindicated if CrCl&lt;30</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
</tr>
<tr>
<td></td>
<td>Takes 5-8 days for full effect</td>
</tr>
<tr>
<td></td>
<td>For patients with goal of abstinence</td>
</tr>
</tbody>
</table>

Rosner et al, Cochrane Database Syst Rev, 2010
FDA-approved medications for AUD:
Disulfiram

<table>
<thead>
<tr>
<th>Dosage</th>
<th>250-500 mg by mouth daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism</td>
<td>Inhibits aldehyde dehydrogenase</td>
</tr>
<tr>
<td></td>
<td>Causes aversive alcohol-disulfiram reaction</td>
</tr>
<tr>
<td>Pros</td>
<td>Use in highly structured environment (e.g. opioid treatment program) or for patients with history of success with disulfiram</td>
</tr>
<tr>
<td>Cons</td>
<td>• Very unpleasant</td>
</tr>
<tr>
<td></td>
<td>• Adherence critical</td>
</tr>
<tr>
<td></td>
<td>• Must have goal of abstinence</td>
</tr>
<tr>
<td></td>
<td>• Concerning in setting of pregnancy, CAD, severe mental illness</td>
</tr>
<tr>
<td></td>
<td>• Liver concerns</td>
</tr>
</tbody>
</table>

Skinner et al, 2014

Non-FDA approved for AUD:
Topiramate

• Titrate up to 300mg/day over 8 weeks: Wk1 25 mg qhs, Wk2 25 mg BID, Wk3 50 mg BID, Wk4 75 mg BID, Wk5 100 mg BID, Wk6 150 BID
• Beneficial for people with seizures, insomnia
• Significant adverse effects of cognitive impairment, paresthesia, sedation, appetite suppression
• Cannot abruptly discontinue
• May combine with Naltrexone

Guglielmo et al, 2015; Blodgett et al, 2014
Non-FDA approved for AUD: Gabapentin

- Studied at 900-1800 mg/day with mixed evidence
- May be useful for people with h/o withdrawal
- Can also use for non-severe alcohol withdrawal
- Dose adjust for CKD
- May combine with Naltrexone
- May be helpful with neuropathic pain, insomnia
- Misuse potential?

Johnson et al., JAMA, 2006; Mason et al.; Falk et al., 2019; Anton et al., 2020

Non-FDA approached for AUD: Baclofen

- Safe for use in liver failure, but mixed evidence
- In 165K patients in France treated with meds for AUD, baclofen was associated with hospitalization (HR 1.1) and mortality (HR 1.3) in dose response relationship
- Concern for very significant harms

Ciagnot et al, 2018
Psychosocial Treatments

Clinical trials have not found any one intervention to be superior to the others.

Which talking therapies work for people who use drugs and also have alcohol problems? Cochrane Review, 2018

Psychosocial Treatments

AA & 12-step programs:
- A recent review appeared to report AA effectiveness in >10K people
- Studies tested AA in conjunction with psychotherapy, and had substantial risk of bias

Kelly, Humphreys, & Ferri, 2020
Virtual recovery resources

- Online support groups
  - 12-step, e.g. AA
  - SMART Recovery
  - LifeRing
  - Moderation Management
  - Women for Sobriety
  - And more
- Apps
- Podcasts

Links to more resources:
- American Society for Addiction Medicine’s guidance on promoting support group attendance during Covid-19
- Accessing treatment through telehealth by National Institute on Alcohol Abuse and Alcoholism

Leverage shared decision-making for treatment

Motivational Enhancement Therapy
Cognitive Behavioral therapy
Family Behavioral Therapy
Medication
12-Step Facilitation
Community Reinforcement Approach
Contingency Management

National Council for Behavioral Health, 2018
Part III. Ambulatory management of alcohol withdrawal

Map 3: States That Have Closed On-Premise Establishments During COVID-19 (as of 4/13/2020)

State Alcohol-Related Laws During the COVID-19 Emergency for On-Premise and Off-Premise Establishments, NIAAA.
Assessing safety of ambulatory withdrawal management

**Can the patient be safely monitored in an ambulatory care setting or at home?**
- Does the patient have safe housing and support?
- Can the patient maintain telephone-based contact?
- Can the patient follow medication instructions? Take orally?
- Does your clinic have the capacity to provide remote monitoring and/or accessibility for patients with alcohol withdrawal syndrome?

**Does the patient need inpatient care?**
- Are they at risk of severe or complicated withdrawal?
- Does the patient have a history of seizures or delirium tremens?
- How severe are their symptoms?
- Does the patient have acute illness, medical co-morbidities or co-occurring substance use likely to complicate their withdrawal treatment?
- Age 65 or over?
- Pregnant?

American Society of Addiction Medicine, 2020

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Who will develop severe withdrawal?

- History of delirium tremens (DT) most predictive in hospitalized patients
- Prediction of Alcohol Withdrawal Severity (PAWSS) is a screening tool to predict severe withdrawal in a medically ill patient
- PAWSS Scores ≥4 suggest high risk. Prophylaxis and/or treatment may be indicated

Wood et al, 2018; Maldonado et al, 2014
Medications for outpatient withdrawal management

• **Benzodiazepines**
  - Prevent seizures so generally considered 1st line
  - Consider reserving for patients with history or risk of severe withdrawal
  - Significant concerns for delirium, CNS depression and misuse
  - Longer-acting (chlordiazepoxide) preferred
  - Shorter-acting without active metabolites (lorazepam) preferred for impaired liver function or risk of oversedation

• **Gabapentin**
  - As effective as benzodiazepines in treating symptoms other than seizures and DT
  - Best as adjunct or for mild-moderate alcohol withdrawal symptoms in low risk patients
  - Can continue for maintenance treatment of AUD
  - 1200mg/day in divided doses tapered over 4-6 days

• **Carbamazepine**
  - As adjunct or for lower risk patients who do not tolerate gabapentin
  - More side effects, e.g. dizziness, drowsiness, nausea, drug interactions
  - 800mg/day in divided doses tapered over 5-9 days

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Example protocols

| Outpatient Fixed Schedule Benzodiazepine Dosing Protocol
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chlordiazepoxide</strong></td>
</tr>
<tr>
<td><strong>Day 1</strong></td>
</tr>
<tr>
<td><strong>Day 2</strong></td>
</tr>
<tr>
<td><strong>Day 3</strong></td>
</tr>
<tr>
<td><strong>Day 4</strong></td>
</tr>
<tr>
<td><strong>Day 5</strong></td>
</tr>
</tbody>
</table>

Gasper & DiPaula, 2020; Muncie et al, 2013
Example protocols

**Gabapentin** is dosed as 600mg PO TID plus an additional 600mg prn once daily for the first week, followed by a 300mg taper after the first week.

<table>
<thead>
<tr>
<th>Taper schedule: Gabapentin Mono therapy (fixed schedule dosing)</th>
<th>Days</th>
<th>Gabapentin Mono therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,200mg BID plus 1,200mg q1 pm</td>
<td></td>
</tr>
<tr>
<td>2-7</td>
<td>600mg TID plus 600mg q1 pm</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>300mg TID</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>300mg BID</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>300mg daily</td>
<td></td>
</tr>
</tbody>
</table>

*Consider 1200mg/day in divided doses tapered over 4-6 days, e.g. 600mg TID or 300mg QID*

Sample protocol courtesy of ASAM and Dr. Brian Hurley, disclaimer

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Example protocols

**Carbamazepine** is dosed 200mg PO QID x 72† followed by a 200mg reduction q72†

<table>
<thead>
<tr>
<th>Taper schedule: Carbamazepine Mono therapy (fixed schedule dosing)</th>
<th>Days</th>
<th>Carbamazepine Mono therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>200mg QID</td>
<td></td>
</tr>
<tr>
<td>4-6</td>
<td>200mg TID</td>
<td></td>
</tr>
<tr>
<td>7-9</td>
<td>200mg BID</td>
<td></td>
</tr>
<tr>
<td>10-11</td>
<td>200mg q15s</td>
<td></td>
</tr>
</tbody>
</table>

*How to write the prescription:* Rx Carbamazepine 200mg tabs, take 1 QID x3d, then 1 TID x3d, then 1 BID x3d, then 1 q15s x3d, #30, NR

*Verbalized or printed instructions for the patient:* Days 1-3: Take 1 four times throughout the day Days 4-6: Take 1 three times throughout the day Days 7-9: Take 1 twice a day Days 10-11: Take 1 at bedtime

Sample protocol courtesy of ASAM and Dr. Brian Hurley, disclaimer
Monitoring considerations

- Reassess patient frequently, ideally daily, for symptoms and medication reconciliation
- Family member or close contact can help monitor patient and dose medications
- If patient not at risk for severe withdrawal, may not need medications if > 24 hours with no or mild symptoms
- Consider dispensing limited supply q24-72 hours depending on patient risks and adherence

<p>| TABLE 1. Alcohol Withdrawal Severity |
|-------------------------------------|----------------------------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Severity Category</th>
<th>Associated CIWA-Ar Range*</th>
<th>Symptom Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>CIWA-Ar &lt; 10</td>
<td>Mild or moderate anxiety, sweating and insomnia, but no tremor</td>
</tr>
<tr>
<td>Severe</td>
<td>CIWA-Ar ≥ 10</td>
<td>Severe anxiety and moderate to severe tremors, but not confusion, hallucinations, or seizures</td>
</tr>
<tr>
<td>Complicated</td>
<td>CIWA-Ar ≥ 19</td>
<td>Severe or sign and symptoms indicative of delirium — such as an inability to follow or understand questions or conversation, disorientation to time or place, or new onset of hallucinations</td>
</tr>
</tbody>
</table>

*Strength of this document, incorporate examples for withdrawal severity using the CIWA-Ar, although others can be used. Regardless of the instrument used, there is wide variability in the literature with regards to withdrawal, threshold value and severity of withdrawal. Classification of withdrawal severity is arbitrary and in the judgment of the clinician and the choice of reference range may be based on their particular patient population or capabilities.

Short Alcohol Withdrawal Scale (SAWS)

- Patient-administered tool to assess the severity of alcohol withdrawal.
- Patients indicate how they have felt in the previous 24 hours. Moderate to severe withdrawal ≥ 12 points.
- Clinicians can also use Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)

<table>
<thead>
<tr>
<th>Item</th>
<th>None (0 points)</th>
<th>Mild (1 point)</th>
<th>Moderate (2 points)</th>
<th>Severe (3 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious</td>
<td>Feeling confused</td>
<td>Restless</td>
<td>Miserable</td>
<td>Problems with memory</td>
</tr>
<tr>
<td></td>
<td>Tremor (shakes)</td>
<td>Nausea</td>
<td>Heart pounding</td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td></td>
<td>Sweating</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ambulatory management of alcohol withdrawal

- Transition to higher level of care if any escalating symptoms, CIWA>20, SAWS>16, distress, altered mental status or seizure
- Duration of treatment may last between 1-7 days
- Recommend regular diet, hydration, safe and relaxing environment, and consider multivitamin containing thiamine and folate
- Don’t forget medications for AUD!

Resource: ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, 2020

Part IV. Harm Reduction Approaches
Harm reduction techniques

• Avoid mixing alcohol with other substances, especially CNS depressants
• Pre-plan intoxication periods and the circumstances: Plan ride, bring condoms, log out of internet
• Count # of drinks and pay attention to the size of drink
• Spread out drinks over time
• Use pocket breathalyzer to monitor self, especially before driving
• Alternate drinks with non-alcoholic ones
• Eat before and during drinking
• Add ice to drink
• OK to continue most prescribed medications, except sedatives and disulfiram


Primary care for people who drink alcohol

• Up to date cancer screening
• Screening: IPV, Falls, Cognitive, Depression, CV Risk
• Heavy alcohol prompts osteoporosis screening before age 65
• Vaccines: PPV-23 x 1 19-64yo and x2 >65yo, Tdap, HAV, HBV, Tetanus, HPV
• Consider TB risk
• Assess nutritional status
• Review medications for interactions with alcohol
• Assess for other substance use including tobacco
• Offer family planning

California Society for Addiction Medicine, 2020
Words matter in order to reduce stigma

<table>
<thead>
<tr>
<th>Use person-first language</th>
<th>Use clinically-accurate language</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Person who drinks alcohol” rather than “alcoholic” or “drunk”</td>
<td>• “Alcohol use disorder,” “unhealthy alcohol use,” or “high-risk alcohol use” rather than “alcohol abuse”</td>
</tr>
<tr>
<td></td>
<td>• “Remission” rather than “sober”</td>
</tr>
<tr>
<td></td>
<td>• “Recurrence” rather than “relapse”</td>
</tr>
</tbody>
</table>

Kelly & Westerhoff, 2010; National Institute on Drug Abuse, 2010

Summary Points:
Management of Alcohol Use Disorder

1. Screen all adults for unhealthy alcohol use
2. Use brief counseling for at-risk drinking AND prescribe medications for alcohol use disorder
3. Apply a patient-centered approach to medical and psychosocial treatment selection based on goals and co-morbidities
4. Consider outpatient withdrawal management for patients without history and symptoms of severe withdrawal
5. Treat alcohol use disorder even when abstinence is not the goal
Our services are accessible via phone or website

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<th>Service</th>
<th>Description</th>
<th>Contact Information</th>
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| Substance Use                  | Evaluation and management                                                    | National Warmline: (855) 300-3595  
California Substance Use Line: (844) 326-2626 |
| HIV/AIDS Warmline              | HIV testing, ARV decisions, complications, & co-morbidities                  | (800) 933-3413              |
| Perinatal HIV Hotline          | Pregnant women with HIV or at-risk for HIV & their infants                   | (888) 448-8765              |
| PrEPline                       | Pre-exposure prophylaxis for persons at-risk for HIV                         | (855) HIV-PRP               |
| Hepatitis C Warmline           | HCV testing, staging, monitoring, & treatment                                | (844) 437-4636 or (844) HEP-INFO |
| PEPline                        | Occupation & non-occupational exposure management                           | (888) 448-4911              |

Questions can also be submitted securely via [nccc.ucsf.edu](nccc.ucsf.edu)

Thank you!

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Reduction of drinking:
An appropriate clinical outcome

• Reductions in drinking levels (grams of ethanol per day) associated with decreased SBP, LFT improvements, better QOL and medication effects
• Reductions may align more with patient’s goals, recognize more people as being successfully treated, encourage more clinician confidence and encourage future medication development
• Other studies prioritize reduction in alcohol-related harm over abstinence or use reduction

Witkewitz et al., 2018; Witkewitz et al., 2019; Falk et al., 2019

What is an optimal outcome in alcohol use disorder treatment?

• Total abstinence is a high standard for evaluating success
• Decrease the number of days drinking
• Decrease the number of days with heavy drinking
• Decrease the number of drinks per day
• Minimize physical, psychological, financial, and social harm
Updated definitions for research are non-abstinence based

Remission from alcohol use disorder as defined by DSM-5 criteria
Requires that the individual not meet any AUD criteria (excluding craving). Remission from AUD is categorized based on its duration: initial (up to 3 months), early (3 months to 1 year), sustained (1 to 5 years), and stable (greater than 5 years).

Recovery from alcohol use disorder
Recovery is a process, achieved if both remission from AUD and cessation from heavy drinking are maintained over time. Recovery is often marked by the fulfillment of basic needs, enhancements in social support and spirituality, and improvements in physical and mental health, quality of life, and other dimensions of well-being.